WHITMAN HOSPITAL & MEDICAL CENTER	Subject: **CREDIT AND COLLECTION**

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Supersede Dates: 06/07; 12/15	☐ New ☒ Revised ☐ Reviewed		
		☒**Policy** ☐**Procedure** ☐**Protocol**	
		Originating Department: Administration	Affected Departments: All

DEFINITION/PURPOSE

It is the policy of the Whitman Hospital and Medical Center (WHMC) to take care of patients first. To take care of patients requires us to take care of business. These policies work to take care of patients and business concurrently.

Patients are ultimately responsible for their account balance. The hospital will bill third party payers as a courtesy to the patient only when all needed billing information is provided to the billing office in a timely manner, preferably prior to the care being provided. If accounts are not paid by third party payers within 45 days then the patient must make other arrangements for payment. To that end, payment plans or other arrangements are to be made prior to providing the service except in emergent situations where the information will be obtained after receiving service.

To the extent that patients do not pay within the timeframes indicated in the attached procedures or do not follow through on the established payment plans their accounts will be sent to collection and their ability to use hospital services in the future may be limited. Whitman Hospital reserves the right to use outside agencies for account processing, management and collection.

The hospital Board of Commissioners will receive an annual summary report of collection actions taken. Accounts sent to collection must be approved by the Chief Financial Officer (CFO) or the Administrator in the absence of the CFO. Although the hospital will pursue collection of delinquent accounts, the hospital will not place a lien on a primary residence.

PERSONNEL

Policy Owner: Chief Financial Officer
Applicability: All hospital personnel

COMPETENCIES

N/A

GENERAL INFORMATION

N/A

EQUIPMENT AND SUPPLIES

N/A

PROCEDURE

A. Services: In general, there are four types of services that the hospital provides, Emergency services, inpatient services (surgeries and acute care), other outpatient services (generally elective) and other services not fitting under the definition of the ones listed above. Each service has different laws that cover financial responsibility of both the patient and the hospital. As a result policies exist for each type.
   1. Emergency Services - These services are provided for life threatening situations (perceived or real). As a result they are required to be provided when a person presents themselves to the ER and often require the use of significant resources in a short period of time. The charge for these services is often higher then what a person would see in a less emergent situation. Legal requirements require the hospital to provide care to stabilize the patient prior to being able to determine if they can pay. In fact it is a requirement that we provide these services regardless of the patient's ability to pay. As a result we will provide care, ask financial questions when allowed and take care of payment after the fact.
   2. Inpatient Services - Inpatient services happen either through a direct admission by a physician or as a result of an emergency.
   3. Outpatient Services - Outpatient services are in general provided in a non-emergent situation. They can however be unexpected. Outpatient services can be provided by any department of the hospital.
   4. Other services - These services cover services not traditionally thought of being provided in a hospital setting. They include but are not limited to Swing Bed, Professional Services and others.

B. Payers: There are many different payers but they in general fall into a few categories including Governmental payers, Private Insurance and Private Pay individuals. Each payer has their own procedures for pre- authorization as well as billing requirements. Below is a summary of some of the basic issues that need to be dealt with by insurance type.
   1. Regardless of the payer each patient must sign a payment plan agreement as part of the admission process. This agreement will include a payment schedule for each account established. Each patient may be evaluated to determine if they have any credit issues. To determine this, the admitting clerk will check with the billing department or use other procedures as defined to determine the ability to pay. If a patient is not able to pay then the account will be referred to the billing department for further evaluation. If the patient requires emergency services as defined by the State of Washington, then the credit check as well as payment agreement procedures as defined in this paragraph are suspended until the patient is stabilized and able to sign a payment agreement. In all other cases payment agreements and credit checks will be performed.
   1. Private Pay Patients
      a. Every patient is in general a private pay individual. Most insurance plans have deductibles or co-pays. Patients may also have a Health Savings Account (HSA). The HSA is designed to cover costs of medical care. Each patient must sign a payment agreement and establish credit according to the collection policies and procedures. We reserve the right to perform a credit check on any account subject to the collection laws governing the State of Washington. The hospital reserves the right to sell any receivable to a lending institution.
      b. Once credit is granted either internally or externally a payment agreement will be put in place. As long as a patient fulfills their responsibility under the payment agreement no other action will occur. If payments are not paid according to an approved payment plan then collection will be pursued with an outside agency.
   2. Governmental Payers
      a. Medicare
         1) Medicare has defined their coverage by types of service. Each service is treated differently from a billing standpoint both from how you bill as well as co-pays or deductibles owed by the patient. Below is a general list and procedure for each service.
         2) Inpatient Services are paid by DRG or predetermined amount per diagnosis for Medicare from a patient's standpoint. To the extent that a patient has not met their "per episode of illness deductible" they will be responsible for that portion on their own. Many patients have supplemental insurance that will cover most or all of this

deductible. The patient will need to have a payment agreement for the portion not covered by supplemental insurance.

3) Outpatient Services are generally paid according to an 80/20 split of allowable charges, fee schedule or other method. In addition to the 20% co-pay there is an annual deductible amount. Both the co-pay and deductible amount will be the responsibility of the patient. Many patients have a supplemental insurance policy that will cover most or all of this deductible. The patient will need to have a payment agreement for the portion not covered by supplemental insurance.
4) Physicians and some clinical services are paid according to a fee schedule and the patient is responsible for a portion of this fee. Many patients have a supplemental insurance policy that will cover most or all of this deductible. The patient will need to have a payment agreement for the portion not covered by supplemental insurance. Payment agreement will be for total amount of services but in the end will end up being for amount not covered by supplemental insurance.
5) Transitional Care/Swing Bed Services are paid after a three day acute care stay, and if they are receiving qualifying services, Medicare pays for the first 20 days at 100%. The next 80 days require a deductible, be paid for each day and Medicare will pay the balance. This may or may not be covered by the supplemental insurance policy. This again is per benefit period or episode of illness. An episode of illness begins when a patient enters the hospital for an acute stay and ends when they have been out of the hospital and have not received skilled care in another facility for 60 consecutive days.

b. Medicaid
1) Medicaid has defined their coverage by types of service. In addition there are different programs that each have different spend down amounts. Each service is treated differently from a billing standpoint both from how you bill as well as co-pays or deductibles owed by the patient. Below is a general list and procedure for each service.
2) Inpatient Services are paid at 100% of allowable rates.
3) Outpatient Services are paid on a percentage of charges based on the rural cost percentage calculated by DSHS.
4) Swing Bed services are paid on an amount per day.
5) Clinic Services are paid according to a fee schedule and the patient may be responsible for a portion of this fee if they exceed the services allowed by Medicaid. In that case they would need a payment agreement and a notice of non-coverage. Payment agreement will be for the estimated amount owed by the patient.
6) Nursing Home Services are paid according to the DSHS payment schedule.

3. Private Insurance Coverage:
a. Private insurance coverage comes in many different forms. Regardless of the program the hospital is ultimately paid either on a percentage of charges or on a fixed amount for a service (Per diem or fee schedule). The hospital also has many hoops that must be jumped through before payment is allowed. This can include items that must be done prior to providing the service or while the service is being provided.

4. Co-Pays and Deductibles:
a. Many insurance plans utilize Co-Pays or Deductibles as part of the total payment for services. When the insured has a co-pay or deductible, as part of their plan the hospital will expect payment of these amounts at time of service. When the co-pay is based on the total bill an average of prior patient bills for a like procedure will be used to estimate the co-pay amount. At the time of the final bill the account will be reconciled and the patient will receive either a refund or a final bill for the remaining balance due.

5. Service Charges:
a. Interest of 12% APR may be charged on any account older than 30 days or 45 days after primary insurance has paid. A $25.00 service charge will be assessed for any returned check.

C. Payment Plans
1. Each patient will be required to either pay his or her account in full prior to or at time of service or sign a payment agreement. Payment of account in full at time of service will be defined as paying an estimated amount for the defined service. Once the actual charges are known the patient will be responsible for or will be refunded the difference between the estimated amount and actual charges.

2. Payment arrangements will be made for balances between $50 and $5,000. Balance over $5,000 will require outside financing whenever possible. Cash discounts will be allowed at time of service up to and including ten (10) days following a patient visit. Cash discounts may be negotiated beyond the standard amount of fiver percent (5%) for larger private pay accounts or as part of an account payment negotiation.

D. Payment Agreements
   1. Payment in Full
      a. Apply balance to credit card
      b. Personal loan to pay the balance
   2. 3 Equal Payments
   3. Set up Payment Arrangement

Balance	Monthly Minimum Payment
$0-$50	PIF
$51-$100	$25
$101-$200	$30
$201-$300	$35
$301-$400	$40
$401-$500	$45
$501-$600	$50
$601-$700	$55
$701-$800	$60
$801-$900	$65
$901-$1000	$70
$1001-AND UP	6% (balance x .06=$MMP)

E. Administrative Appeal Process
   1. Matters requiring administrative review will be done by an individual or committee. The issues that could be subject to administrative appeal include charity care determination appeal, service charge adjustment, acceptance of payment plans not in accordance with established parameters, and other matters not able to be determined under the defined credit policies and procedures.
   2. A judgment on most matters will be made by the CFO and approved by the Administrator only when amounts are greater than $500 or the situation warrants additional review. Part or all of the procedures may be used based on the judgment of the CFO and Administrator.

F. Charity Care Policy
   1. WHMC is committed to the provision of health care services to all persons in need of medically necessary care regardless of the ability to pay. In order to protect the integrity of operations and fulfill this commitment, the following criteria for the provision of charity care will assist staff in making consistent and objective decisions regarding eligibility for charity care while ensuring the maintenance of a sound financial base.

G. Notification
   1. The hospital will provide a written notice to all patients informing them about the availability of charity care and financial assistance at the time the hospital requests information regarding third party coverage. The written notice also will be verbally explained. In the case of patients receiving emergency services, the notice will be provided as soon as possible.
   2. Information about the hospital's charity care policy also shall be publicly available through the posting of signs in public areas of the hospital.

H. Description of Eligibility Criteria
   1. Charity care is generally secondary to all other financial resources available to the patient, including group or individual medical plans, worker's compensation, Medicare Medicaid or medical assistance programs, other state, federal, or military programs, third party liability situations (e.g., auto accidents or personal injuries), or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical services.
   2. Patients will be granted charity care or financial assistance regardless of race, creed, color, national origin, sex, sexual orientation, or the presence of any sensory, mental, or physical disability or the use of a trained dog guide or service animal by a disabled person.
   3. Any patient receiving emergency services at our facility is eligible to apply for charity care or financial assistance. Only patients residing in Whitman Hospital District #3 will be eligible to apply for charity care or financial assistance when the services are elective, routine, or otherwise non-emergent. Financial assistance and charity care shall be limited to “appropriate hospital-based medical services” as defined in WAC 246-453-010(7).

Exceptions for those residing outside of Whitman Hospital District #3 may be made for catastrophic situations that create a severe financial hardship or personal loss. Exceptions will be done on a case by case basis by administration per the denial and appeal process on page 6 of this policy.

4. In those situations where appropriate primary payment sources are not available, patients shall be considered for charity care under this hospital policy based on the following criteria as calculated for the 12 months prior to the date of request.
5. The full amount of hospital charges will be determined to be charity care for any patient whose gross family income is at or below 100% of the current federal poverty guidelines (consistent with WAC 246-453).
6. The following sliding fee schedule shall be used to determine the amount to be written off for patients with incomes between 100% and 300% of the current federal poverty level.
7. Applicants whose income is greater than 100% of the poverty guidelines and less than 125%, will receive a reduction in their bill of 85%.
8. Applicants whose income is greater than 125% of the poverty guidelines and less than 150%, will receive a reduction in their bill of 70%.
9. Applicants whose income is greater than 150% of the poverty guidelines and less than 175%, will receive a reduction in their bill, of 55%.
10. Applicants whose income is greater than 175% of the poverty guidelines and less than 200%, will receive a reduction in their bill of 40%.
11. Applicants whose income is greater than 200% of the poverty guidelines and less than 300%, and who are uninsured will receive a reduction in their bill of 22%.
12. The hospital may write off as charity care, amounts for patients with family income in excess of 300% of the federal poverty level when circumstances indicate severe financial hardship or personal loss.

I. Process for Eligibility Determination

1. During the admission process patients will be asked if they might need assistance paying their bill (except for patients receiving emergency services who will be contacted at a later date) and provided a copy of the charity care notice. Patients will receive a credit and collection brochure and be asked to apply for Medicaid if they appear to be eligible and have not applied. If patients feel they might need assistance, they will be given an application to fill out and sign at that time.
2. Initial determination: The initial determination of eligibility for financial assistance will be made at the time of admission or as soon as possible following initiation of services to the patient. Pending final eligibility determination, the hospital will not initiate collection efforts or requests for deposits, provided that the responsible party is cooperative with the hospital's efforts to reach a determination of sponsorship status. The patient will be asked to return income verification information to the hospital within 14 days.
3. Final Determination: Prima Facie write-offs. The hospital may choose to grant charity care based solely on the initial determination. In such cases, the hospital may choose to not complete full verification or documentation of any request.
4. Charity care forms, instructions and written applications shall be furnished to patients when charity care is requested, when need is indicated or when financial screening indicates potential need. All applications, whether initiated by the patient or the hospital should be accompanied by documentation to verify income amounts indicated on the application form. The following are examples of what may be requested for the purpose of verifying income.
    a. W-2 withholding statements for all employment during the relevant time period;
    b. Pay stubs from all employment for the last three months and or information about current employment;
    c. An income tax return from the most recently filed calendar year;
    d. Forms approving or denying eligibility for Medicaid and/or state-funded Medical Assistance;
    e. Forms approving or denying unemployment compensation; or
    f. Written statements from employers or welfare agencies.
5. Patients may be asked to provide verification of ineligibility for Medicaid or Medical Assistance. During the initial request period, the hospital may pursue other sources of funding including Medicaid.
6. Income shall be annualized from the date of application based upon documentation provided and upon verbal information provided by the patient. The process for annualizing income will

be determined by the hospital and will take into consideration seasonal employment and temporary increases and/or decreases of income.

7. Family assets will be considered as a part of the final determination of charity care or financial assistance if the family income exceeds 100% of the federal poverty level. The hospital may ask for bank statements, investment statements, and other information regarding assets.
8. In the event that the responsible party is not able to provide any of the documentation described above, the hospital will rely on written and signed statements from the patient for making a final determination of eligibility.
9. The hospital will notify the patient of its final determination of eligibility for charity care or financial assistance within fourteen (14) days of receipt of all application and documentation material. If the hospital confirms that no other financial resources are available to pay for the services and the patient meets the income eligibility, the billing department will apply the criteria mentioned above and determine the amount of charity care to be granted.
10. Denials: Denials will be written and include the basis for the denial along with instructions for appeal or reconsideration as follows. The patient/guarantor may appeal the determination of ineligibility for charity care by providing additional verification of income or family size to the Business Office Manager within thirty (30) days of receipt of notification. All appeals will be reviewed by the CFO. If the determination on appeal affirms the previous denial of charity care, written notification will be sent to the patient/guarantor and the Department of Health in accordance with state law. Final appeal process will conclude within 30 days of the receipt of a denial by the applicant.

J. Documents and Records
   1. Confidentiality: All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the application form.
   2. Documents pertaining to charity care shall be retained for six (6) years.

DOCUMENTATION

N/A